STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375493	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartsworth Center for Nursing & Rehabilitation	1200 West Canadian Avenue Vinita, OK 74301

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 30267 Based on observation, record review, and interview, the facility failed to assist a resident with their meal in a dignified manner for one (#10) of eight residents observed for dining. The DON identified three residents who required total assistance with meals. Findings: The facility's Assistance with Meals policy, documented that residents who could not feed themselves would be fed with attention to dignity. As examples, the policy documented not to stand over residents while assisting them with their meals and to keep interactions with other staff to a minimum while assisting residents with their meals. On 04/29/24 at 10:53 a.m., Resident #10 was reclined in a geri-chair, in the dining room. Facility staff stood beside the resident and assisted the resident with their meal. The staff member was heard to talk with various other staff members as they stood beside Resident #10. On 05/01/24 at 11:20 a.m., Resident #10 was reclined in a geri-chair, in the dining room. CNA #4 stood beside the resident and assisted the resident with their meal. The staff member was heard to talk with various other staff members as they stood beside Resident #10. On 05/02/24 at 1:09 p.m., CNA #4 stated when they assisted a resident with their meal, they placed a protective cover over the resident's clothing and sat in front of the resident to assist with the meal. CNA #4 stated they thought in was more sociable to sit while assisting a resident with their meal because you could talk with the resident. On 05/02/24 at 1:21 p.m., CNA #5 stated if they assisted a resident with their meal, they sat beside them. The CNA $5 stated when they sat beside the resident, they could have a more casual conversation with them. The CNA#5 stated if they were to stand while they assisted the resident, the act would feel clinical or as though they were looming over the resident. On 05/02/24 at 2:24 p.m., the DON stated they expected their staff to sit down to assist a resident with their meal.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 34270 Based on record review and interview, the facility failed to provide education about advance directives and provide an opportunity for a resident to have or decline an advance directive for one (#63) of 24 sampled residents reviewed for advance directives. A facility daily census report, dated 04/29/24, documented 73 residents resided at the facility. Findings: A review of Resident #63's EMR found any documentation of an advance directive. The EMR did contain an order for full code but no paperwork that it was discussed with the resident or a representative was found in the records. On 05/01/24 at 7:25 a.m., the ADON stated they had reviewed Resident #63's records and did not find documentation of an advance directive. They stated they did find a physician's order for full code status but not the paperwork that code status was discussed with the resident or a representative. On 05/01/24 at 7:59 a.m., the ADON stated the resident did not have an advance directive and there was no documentation in their records they were given education on advance directives or given the opportunity to accept or decline the creation of one.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 30267 Based on observation and interview, the facility failed to provide privacy for one (#44) of one resident observed to have a facility camera in their room. The DON identified there were two residents for which the facility had placed a camera in the residents' rooms. Findings: The comprehensive assessment, dated 01/20/24, documented the resident was severely impaired in cognition, experienced an acute change in mental status, and exhibited no behaviors such as wandering or rejection of care. The quarterly assessment, dated 04/10/24, documented the resident was severely impaired in cognition, experienced an acute change in mental status, and exhibited no behaviors such as wandering or rejection of care. On 04/29/24 at 09:30 a.m., Resident #44 was interviewed in their room while they were in bed. There was a camera positioned on the opposite wall from the resident's headboard and faced toward the bed. Resident #44 stated they had difficulty hearing. The resident responded to open ended questions, including questions regarding the use of a camera in their room, with inappropriate responses of yes or no. On 04/29/24 at 9:56 a.m., RN #1 stated Resident #44 had a camera in their room. There was a small portable monitor located on the top of the half wall which ran along the front of the nurses' station. RN #1 pressed a button on a small portable monitor and the screen depicted Resident #44 lying in their bed. The RN #1 stated the resident often fell when they transferred themselves to and from the bed to their wheelchair. The RN #1 stated the camera had been used at least since the first of the year when they had started working with the resident. 04/29/24 at 2:28 p.m., Resident #44 laying perpendicular in bed with legs stretched out and supported by seat of wheelchair. RN #1 performed an assessment on Resident #44. The camera was in the room, pointed toward the bed. On 04/29/24 at 2:30 p.m., the camera monitor was on the half wall in front of the nurses' station. The monitor laid on its back with the screen facing upward toward the ceiling. Other residents, visitors, and staff were observed to walk, propel, and/or stand within a few feet of the monitor. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/30/24 at 11:15 a.m., Resident #44 was in bed. The camera was on the wall, facing the bed. The monitor was on the half wall in front of the nurses' station with the screen facing toward the interior of the nurses' station. Other residents and staff were observed to walk, propel, and/or stand within a few feet of the monitor. On 04/30/24 at 2:40 p.m., Resident #44 was in bed. The camera was on the wall, facing the bed. The monitor was on the half wall in front of the nurses' station with the screen facing toward the ceiling. Other residents and staff were observed to walk, propel, and/or stand within a few feet of the monitor. On 05/01/24 at 10:25 a.m., Resident #44 was in bed. The camera was on the wall, facing the bed. The monitor was on the half wall in front of the nurses' station with the screen facing toward the interior of the nurses' station. Other residents and staff were observed to walk, propel, and/or stand within a few feet of the monitor. On 05/01/24 at 2:32 p.m., Resident #44 was in bed. The camera was on the wall, facing the bed. The monitor was on the half wall in front of the nurses' station with the screen facing toward the ceiling. Other residents and staff were observed to walk, propel, and/or stand within a few feet of the monitor. On 05/02/24 at 9:57 a.m., RN #2 stated they did not know of the camera until recently when they noticed it was on the wall. They stated when they had inquired about the camera, they were told it had been there for a few months. On 05/02/24 at 10:06 a.m., RN #1 stated the staff provided for privacy by pulling privacy curtains for the residents in a semi-private room and closing bedroom doors before providing resident care. The RN stated to provide privacy for Resident #44, they kept the monitor facing inward toward the nurses' station. The RN #1 stated the screen timed out after a minute or so but all you had to do was press a button on the monitor to view the screen again. On 05/02/24 at 10:49 a.m., the ADON stated the facility notified the Power of Attorney, family, or other responsible party for the resident of the use of the camera as a fall intervention. The ADON stated the care plan should document the use of the camera as a fall intervention. The ADON reviewed the clinical chart for Resident #44 and stated the resident was their own responsible party. They stated the resident's care plan did not address the use of a camera. The ADON stated there was no physician's order for the use of the camera and no documentation of when or why the camera was used. The ADON stated there was no documentation Resident #44 was notified or agreed to the use of a camera in their room. On 05/02/24 at 10:50 a.m., the DON stated the camera was used as a last ditch effort fall intervention before utilizing a private sitter. The DON stated the monitor was to be secluded in the nurses station or carried by a staff member in a manner to allow for privacy. The DON stated the use of a camera should be routinely reviewed for the appropriateness as a fall intervention. The DON stated the facility did not have a procedure for the use of a facility's camera in a resident's room. On 05/02/24 at 10:51 a.m., the administrator stated the facility did not have a policy or procedure for the facility's use of a camera in a resident's room.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 42171 Based on record review and interview, the facility failed to ensure the accuracy of a baseline care plan for one (#219) of two residents sampled for baseline care plan. The administrator reported the census was 73. Findings: An undated facility policy titled Care Plans-Baseline read in part, .The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident . Resident #219 had diagnoses which included hypertension and anemia. A baseline care plan, dated 04/17/24, documented the resident had a pressure ulcer upon admission. An admission skin assessment, dated 04/17/24, documented the resident had normal skin with good elasticity and no new wounds. On 05/01/24 at 1:20 p.m., the ADON stated she was unaware the resident had any skin issues at admit. On 05/02/24 at 9:42 a.m., MDS coordinator #2 stated she was responsible for Resident #219's baseline care plan and the information regarding the pressure ulcer was inaccurate. On 05/02/24 at 1:20 p.m., the DON stated that they were ultimately responsible for ensuring the accuracy of baseline care plans.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 34270 Based on record review and interview, the facility failed to include a focus of wandering in a comprehensive care plan for one (#4) of two residents reviewed for wandering. The ADON identified two residents in the facility that wandered. Findings: A facility Elopements and Wandering Resident policy, dated 01/01/20, read in part, The facility ensures residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with with their person-centered plan of care addressing the unique factors contributing to wandering or elopement. Resident #34 had diagnoses which included recurrent depressive disorder. A progress note, dated 01/26/24 at 8:08 a.m., documented the Resident #34 had been wandering and continued attempting to enter other residents' rooms. A progress note, dated 01/26/24 at 10:02 a.m., documented the Resident #34 was found in their room with the shoes of a male resident. A progress note, dated 01/26/24 at 5:12 p.m., documented the Resident #34 had attempted to enter the kitchen while calling our for their mother. A progress note, dated 02/05/24 at 3:20 p.m., documented required redirection from wandering into the rooms of other residents. A facility Wandering Risk Scale , dated 0225/24, documented the Resident #34 had score a 14 on the risk tool and was documented to be a high risk for wandering. A progress note, dated 03/11/24 at 12:39 p.m., documented the Resident #34 wanders around the facility. A quarterly MDS assessment, dated 03/14/24, documented the Resident #34 cognition was moderately impaired. A review of Resident #34's comprehensive care plan found no focus, goal, or intervention regarding wandering. A focus for falls was in the care plan that documented the resident had fallen on 02/09/24 due to confusion and wandering. One of the interventions for the fall focus was to speak to the resident's family about a locked unit. The goal and other intervention for the fall focus did not address wandering. On 04/30/24 at 7:26 a.m., the ADON stated Resident #34 did wander. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/01/24 at 11:37 a.m., CNA #2 stated the Resident #34 did wander a lot a few months ago but she has since declined and does so less. On 05/01/24 at 11:46 a.m., LPN #2 stated the Resident #34 has really slowed down as far as wandering and that sometimes they may try to go into another resident's room. On 05/02/24 at 09:20 a.m., MDS Coordinator #1 reviewed Resident #34's medical record and stated the resident does not have focus on wandering. They stated they got their ideas for the care plan focuses from documentation in a residents medical record. They stated they do also talk with the staff about each resident when they make out the care plans. They stated that since there were progress notes about wandering in Resident #34's medical record they should have care planned wandering. They stated they were not sure why it was not care planned in the past. On 05/02/24 at 1:14 p.m., the DON stated the care plan system at the facility was broken and the facility leadership will be working to fix it. They stated they need every IDT member to be involved in the care plan meetings.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 30267 Based on record review and interview, the facility failed to ensure the consulting pharmacist documented the correct dosage of a psychotropic medication on a request for dosage reduction for one (#11) of five residents whose clinical records were reviewed for unnecessary medications. The ADON identified 16 residents who received psychotropic medications. Findings: The physician's order, dated 05/11/23, documented the resident was to receive Zoloft 200 mg daily. The request for a gradual dose reduction, dated 06/17/23, documented the resident received Zoloft 100 mg daily. The physician's order, dated 06/26/23 was written on the pharmacist's request for gradual dose reduction and documented to decrease Zoloft to 50 mg daily. The physician's order, dated 07/13/23, documented the resident was to receive Zoloft 200 mg daily. On 05/02/24 at 9:42 a.m., the ADON stated the pharmacist documented an incorrect dosage on the request for gradual dose reduction and the physician may have based their decision to reduce the medication on the inaccurate dosage documented on the gradual dose reduction. The ADON stated the resident had gone to the hospital on 07/13/23 and returned to the facility the same day. The ADON stated it was about that time when the facility identified a problem with the floor nurses not reconciling or confirming the orders with the physician once a resident returned from the hospital. The ADON stated they were now responsible for entering new physician's orders.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 42171 Based on observation, record review, and interview, the facility failed to notify the physician of a wound for one (# 219) of one resident sampled for wounds. The ADON identified seven residents in the facility with wounds. Findings: An undated facility policy titled Change in a Resident's Condition or Status read in part, .Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the residents' medical/mental condition and/or status .The nurse will notify the residents' attending physician or physician on call when there has been a . need to alter the residents' medical treatment significantly . Resident #219 had diagnoses which included hypertension and anemia. An admission skin assessment, dated 04/17/24, documented the resident had normal skin with good elasticity and no new wounds. A nurse note, dated 04/28/24 at 5:42 pm, documented the resident had an open sore on their right buttocks. A review of Resident #219's medical record did not document the physician had been notified regarding the open area. On 05/01/24 at 9:40 am, LPN #1 stated they were aware of a spot on the resident's buttocks and that they had been treating it with barrier cream. They also stated they had not contacted the physician regarding the spot. On 05/01/24 at 9:54 am, an open area was observed on Resident #219's right buttock. On 05/01/24 at 9:55 am LPN #1 stated the area was bigger than it was the last time they saw it on 04/29/24. LPN #1 also stated she had not notified the physician on 04/29/24 because the area was not open. On 05/01/24 at 12:08 pm, the ADON stated their expectation is that anyone that notices an open area should report it immediately so the physician could be notified. On 05/02/24 at 1:20 pm the DON stated the physician should have been notified as soon as the wound was discovered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 34270 Based on observation and interview, the facility failed to prevent a medication room door from being propped open by a chair and the medication room being open and unattended by appropriate staff. A facility daily census report, dated 04/29/24, documented 73 residents resided at the facility. Findings: The facility's Medication Labeling and Storage policy, dated 02/2023, read in part, Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. On 04/30/24 at 6:51 a.m., the facility medication room door was found propped open with a chair and the medication room unattended. There were no staff members observed inside the room or in the hallways next to the room who may have been observing the room. Four locked medication carts were located in the medication room. Various types of resident medications were found in bins located on shelves around the medication room. No unsecured controlled medications were observed. On 04/30/24 at 6:55 a.m., LPN #1 entered the medication room. They stated they someone had used a chair to hold the door open but they did not know who. They stated they had not done so. They stated the medication room should never be left open and unattended. They stated a resident could have entered and taken medications which could have harmed them. On 04/30/24 at 7:29 a.m., LPN #2 stated they had left the medication room door propped open with a chair. They stated they were focused on a resident being sent to out to a hospital that they did not think about the door being left open. They stated they it was not something they would normally do. They stated they understood the consequences of leaving the medication room open and unattended could result in a resident or other person taking medications and harming themselves. On 04/30/24 at 7:56 a.m., the ADON stated a search of the medication room found no missing medication. On 04/30/24 at 8:45 a.m., the DON stated LPN #2 had been counseled about the leaving the medication room open. They stated that should have never occurred and the medicating room must be secured at all times.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 30267 Based on observation, record review, and interview, the facility failed to serve foods at a palatable temperature from one of two kitchen service areas. The DON identified 40 residents who ate meals served from the satellite kitchen. Findings: The facility policy titled Food and Nutrition Services, read it part, Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature. On 05/01/24 at 11:15 a.m., the satellite kitchen was observed. The mid-morning meal, including breakfast and lunch style options were observed on the steam table. The steam table was not producing steam. The back and sides of the steam table felt only warm to the touch. The holding temperature of the sausage patties was 94 degrees Fahrenheit. The holding temperature of the soup from 118 degrees Fahrenheit. On 05/01/24 at 11:16 a.m., Cook #1 stated they were not sure what the holding temperature was for hot foods. The cook stated the steam table was turned on about 7:00 a.m. and left until they were finished with the evening meal. The cook stated they thought the steam table was not hot enough to keep the food hot due to one steam table burner not working and the low water level within the steam table. The Cook #1 pointed to a line inside the steam table water reservoir. The water level appeared approximately three inches below the line the cook pointed to. On 05/02/24 at 10:15 a.m., the steam table was observed with Cook #2. The steam table did not produce steam. The sides of the steam table were warm to the touch. Cook #2 stated the holding temperature of hot foods was at least 135 degrees Fahrenheit. The cook measured the water in the steam table reservoir in two places. The water measured 128 degrees Fahrenheit at the back of the reservoir and 146 degrees Fahrenheit on the side where the knobs controlling the steam table temperature were located. The Cook #2 stated they had noticed trouble with the steam table maintaining temperature and had notified the maintenance department last week about it. On 05/02/24 at 1:30 p.m., the dietary manager stated the holding temperature for hot food was to be greater than 135 degrees Fahrenheit. They stated food temperatures were measured just before sending food from the main kitchen to the satellite kitchen and again immediately after placing the food on the steam table and starting service to the residents. The dietary manager stated they did not measure the holding temperature of the food again. The dietary manager was asked if measuring the temperature of the hot food as soon as it was placed on the steam table was an accurate measurement of the holding temperature of the hot foods during the entirety of the meal service. The dietary manager stated no. They stated measuring the temperature at the start of meal service gave the staff what the food temperature was at the start of of the meal and not what the holding temperature was of the food.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 42171 Based on record review and interview, the facility failed to ensure three substantive meals were served daily. The ADON reported 73 residents received meals from the kitchen. Findings: An undated facility policy titled Frequency of Meals, read in part, .Each resident shall receive at least three (3) meals daily, at times comparable to typical mealtimes in the community, or in accordance with resident needs, preferences, requests, and the plan of care . A handwritten document provided by the DM documented that east hall had breakfast served at 7:30 am, the snack cart went out at 7:30 am, brunch was served at 10:30 am, the snack cart went out again around 1:30 pm, supper was served at 4:30 pm, and the snack cart went out again at 6:30 pm. On 04/29/24 at 8:32 am, the DM stated that a breakfast snack was served in the morning and then brunch which has breakfast items was served. They also stated a midday snack was served then an evening meal was served around 4:30 pm followed by an evening snack. On 05/02/24 at 9:10 am, the DM stated that a hot breakfast was served on the skilled unit, but other residents were served a continental breakfast consisting of pastries, cold cereal, oatmeal, or yogurt. The DM further stated that the residents could request a hot breakfast, but it was not offered to them. On 05/02/24 at 11:40 am, CMA #2 stated breakfast was more of a snack than a meal. On 05/02/24 at 11:49 am, LPN #2 stated she would not consider the breakfast served in the facility a substantial meal. On 05/02/24 at 11:54 am, Cook #1 stated the residents on east hall received a hot meal for breakfast but the other residents in the facility did not. On 05/02/24 at 11:58 am, CMA #1 stated the facility served a continental breakfast not a traditional breakfast.

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	375493	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartsworth Center for Nursing & Rehabilitation	1200 West Canadian Avenue Vinita, OK 74301

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 30267 Based on observation and interview, the facility failed to maintain the physical environment of the main kitchen and failed to serve cold foods in the satellite dining room in a sanitary manner. The DON identified 79 residents who ate meals prepared in the main kitchen. Findings: On 04/29/24 at 8:32 a.m., the kitchen was observed to not have a dedicated handwashing sink. On 04/29/23 at 8:32 a.m., the dietary manager stated the staff used the two compartment sink to wash their hands. The dietary manager stated the two compartment sink was used to fill pots with with water and other food preparation needs. On 04/29/24 at 8:33 a.m., the kitchen was observed to have: - missing and broken baseboards, - holes in the ceiling, - rusted air vents and lighting fixtures in the ceiling, - multiple yellow and orange water stains on the ceiling, - peeling paint located on the ceiling and above the food preparation areas, - no dedicated hand washing sinks in the main or satellite kitchens, - an unsecured bottom grill hanging from under the left door of the two door refrigerator, and - and two (approximately one inch thick and four inch by eight foot) wood beams nailed across the ceilings stained, sagging, and peeling paint. On 04/29/24 at 8:45 a.m., the satellite kitchen was observed with the dietary manager. The satellite kitchen was observed to not have a sink. On 04/29/24 at 8:45 a.m., the dietary manager stated the kitchen staff assigned to the satellite kitchen were to wash their hands in the sink located on the opposite side of the dining room. On 05/01 at 11:30 a.m., multiple nursing staff were observed passing trays from the satellite kitchen. The staff were observed to: - passed trays to residents in the satellite dining room, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- assisted residents with positioning themselves near the table, and - prepared the resident's plate (cutting the food, positioning utensils, plate, and drinks within reach of the resident), and - plate and serve peaches in syrup from a clear container and cottage cheese from a container without sanitizing their hands. The facility staff were observe to place the lid of the peaches container on the island counter with the interior or the lid in contact with the counter top before securing the lid back on top of the container. Between the observations of nursing staff plating cold foods from the dining room island, Resident #20 was observed to plate themselves peaches and cottage cheese from the dining room island without washing or sanitizing their hands. Without sanitizing their hands, the nursing staff were observed to serve cold foods located on the island in the satellite dining room. On 05/02/24 at 1:30 p.m., the dietary manager stated the ceiling damage was there when they started working and they did not know when or how the damage occurred. On 05/02/24 at 2:25 p.m., the DON stated cold foods should be served from the satellite kitchen by the kitchen staff to ensure food was served in a sanitary manner. On 05/02/24 at 2:30 p.m., the kitchen was observed with the administrator. The administrator stated the facility had a pipe burst in the ceiling one holiday and maintenance had made the necessary repairs for food service to continue. The administrator stated there had never been dedicated handwashing sinks in the main or satellite kitchens.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270 Based on record review and interview, the facility failed to provide residents binding arbitration agreements that: a. informed the resident or their representative of their right not to sign the agreement as a condition of admission or continued care; and b. does contains an explicit acknowledged by the resident or their representative that they understood the provisions of the agreement; and c. does not include the name of a second nursing facility, in which the resident does not reside or is aware of, in the agreement for two (#50 and #63) of two sampled resident reviewed for arbitration agreements. The facility SSD stated 60 residents that resided in the facility had signed binding arbitration agreement. Findings: A facility Binding Arbitration Agreements policy, dated 07/18/19, read in part, This facility asks all residents to enter into an agreement for binding arbitration. We do not require binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, this facility .When explaining the arbitration agreement, the facility shall: a. Explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, this facility. b. Explain to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands. c. Ensure the resident or his or her representative acknowledges that he or she understands the agreement. 1. Resident #50 was admitted to the facility on [DATE]. A review of the residents medical record found a digital copy of a binding arbitration agreement signed by the resident on 02/03/23. The agreement did not document the resident could be admitted to the facility without entering into the agreement and did not contain a statement the resident or their representative explicitly understood the provisions of the agreement. The document also contained in one paragraph the name of a second skilled nursing facility. 2. Resident #63 was admitted to the facility on [DATE]. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident medical record found a digital copy of a binding arbitration agreement signed by the resident on 03/21/24. The agreement did not document the resident could be admitted to the facility without entering into the agreement and did not contain a statement the resident or their representative explicitly understood the provisions of the agreement. The document also contained in one paragraph the name of a second skilled nursing facility. On 05/02/24 at 11:53 a.m., the SSD stated they understood a resident was not required to sign an arbitration agreement to be admitted and received services at the facility. They stated if a resident did not want to sign the agreement the SSD would make a note at the bottom of the agreement. They stated the binding arbitration agreement they facility used did not state a person could still be admitted and receive services if they did not enter into a binding arbitration agreement. They stated there was not a section of the agreement that stated the resident or their representative explicitly understood the provisions of the agreement. They stated they are unaware of a policy and procedure related to arbitration agreements at the facility. At 12:25 p.m. Resident #50 stated they did not recall signing a binding arbitration agreement when they were admitted and stated the facility staff gave them so much paperwork they did not know what they were signing. The resident had no knowledge of the second nursing facility included in the agreement. At 12:28 p.m., Resident #63 stated they did not know what a binding arbitration agreement was and could not recall if they had signed one. They stated they did not know of the second nursing facility included in the agreement. At 12:58 p.m., the Administrator stated the current owners of the facility did use binding arbitration agreements and had adopted the arbitration agreement form from the previous owners after the purchase of the facility. They stated that was the form they were using. They stated they understood the shortcomings of the agreement.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 42171 Based on observation and interview, the facility failed to ensure the lint screens were cleared as recommended for three of three dryers observed in the laundry room. The administrator reported the facility census was 73. Findings: On 04/30/24 at 10:25 am, Laundry Employee #1 reported the sign on the dryer indicated the lint screen should be cleaned every 4 hours, but when they were busy, they only cleaned it every eight hours or so. On 04/30/24 at 10:25 am, signs were observed to be affixed to all three dryers in the laundry room, these signs stated the lint screens were to be cleaned every 4 hours. On 04/30/24 at 10:30 am Laundry Employee #1 was asked to remove the cover to expose the lint screen on one of the dryers. Once the cover was removed a considerable amount of lint was observed to be covering the screen. The employee stated they had not cleaned the lint screens today, but they assumed the screens had been cleaned yesterday. On 05/02/24 at 1:50 pm, the maintenance supervisor stated that laundry employees were responsible for cleaning the lint screen and maintenance staff were responsible for cleaning the lint around the fire box.